CLIENT REGISTRATION FORM
NC Department of Health and Human Services -- Division of Aging and Adult Services

Month Day Year
Date of Update

1. **TYPE ACTION** (Check Appropriate Action and Complete Required Items **REGION** ____ **PROVIDER**

- ☐ New **R**egistration-------Items 1-21
  - ☐ **Client Waiting for Service**-----Items 1-10
- ☐ **C**hange----------Items 1-3, 8 Changing Items
- ☐ Report **D**eath----------Items 1-3, 8 (In Item 3, Enter Date of Death)

2. **S.S.N.** 3. **DATE** (Month Day Year) 4. **COUNTY CODE**

5. **RACE** (Enter One) ☐
W-White, B-Black, I-Indian,
A-Asian/Pac. Islander, H-Hispanic

6. **SEX** (Enter One) ☐
M-Male
F-Female

7. **DATE OF BIRTH** (Month Day Year)

8. **NAME** Last First MI

9. **ADDRESS** Line 1 Line 2

CITY **STATE** **ZIP Code** -

10. **TELEPHONE** - -

Information contained on this form will be kept confidential unless disclosure is required by court order or for authorized Federal, State or local program reporting and monitoring. The client's entitlement to Social Security benefits or other federal or state sponsored benefits shall not be affected by the provision of the aforementioned information.

DATE **CLIENT SIGNATURE** **AGENCY EMPLOYEE SIGNATURE**

EMERGENCY CONTACT PERSON **PHONE**

11. **LIVE ALONE** (Check One) ☐ Yes ☐ No

12. **SPECIAL ELIGIBILITY** (Check One) ☐ Yes ☐ No

13. **ECONOMICALLY NEEDY** (Check One) ☐ Yes ☐ No

14. **SERVICE RELIEVES A CAREGIVER** (Check One) ☐ Yes ☐ No

15. **IS CLIENT THE CAREGIVER** (Check One) ☐ Yes ☐ No

16. **TANF** ELIGIBILITY MET (Check One) ☐ Yes ☐ No

17. IS CLIENT ORIENTED (Check One) ☐ Yes ☐ No

18. **# OF IADL IMPAIRMENTS** ☐

19. **# OF ADL IMPAIRMENTS** ☐

20. **NUTRITIONAL HEALTH SCORE** ☐

21. **OVERALL FUNCTIONAL STATUS** ☐ (Well, At Risk, High Risk)